		FOR OHF USE					

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2000
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2000)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0018044

Facility Name: PRAIRIEVIEW LUTHERAN HOME

Address: PO BOX 4 (Number) DANFORTH (City) 60930 (Zip Code)

County: IROQUOIS

Telephone Number: 815-265-2970 **Fax #** 815-269-2930

IDPA ID Number: 362735789001

Date of Initial License for Current Owners: 2/14/74

Type of Ownership:

X	VOLUNTARY,NON-PROFIT		PROPRIETARY		GOVERNMENTAL
X	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code 501 c (3)			Corporation		Other
			"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: CAROL PETERS, ADMIN **Telephone Number:** 815-269-2970

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 1/1/00 to 12/31/00 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider
(Signed) _____ (Date)
(Type or Print Name) CAROL E. PETERS
(Title) CEO/ADMINISTRATOR

Paid Preparer
(Signed) _____ (Date)
(Print Name and Title) BRUCE A. FOX
(Firm Name & Address) FOX CPA GROUP, LTD., 111 N THIRD, WATSEKA, 60970
(Telephone) 815-432-3126 Fax # 815-432-6061

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 Phone # (217) 782-1630

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number PRAIRIEVIEW LUTHERAN HOME # 0018044 Report Period Beginning: 1/1/00 Ending: 12/31/00

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds _____

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	92	Skilled (SNF)	92	33,672	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	92	TOTALS	92	33,672	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	7,616	24,691	552	32,859	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	7,616	24,691	552	32,859	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 97.59%

D. How many bed-hold days during this year were paid by Public Aid?
63 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
N/A

F. Does the facility maintain a daily midnight census? YES

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [X] NO [ ]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [X] NO [ ]

I. On what date did you start providing long term care at this location?
Date started 2/14/74

J. Was the facility purchased or leased after January 1, 1978?
YES [ ] Date _____ NO [X]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 5 and days of care provided 552

Medicare Intermediary MUTUAL OF OMAHA

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 12/31/00 Fiscal Year: 12/31/00

* All facilities other than governmental must report on the accrual basis.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number PRAIRIEVIEW LUTHERAN HOME # 0018044 Report Period Beginning: 1/1/00 Ending: 12/31/00

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger Salary/Wage 1	Supplies 2	Other 3	Total 4	Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR OHF USE ONLY 9	10	
	A. General Services											
1	Dietary	215,307	17,050	7,263	239,620		239,620		239,620			1
2	Food Purchase		183,157		183,157	(2,934)	180,223		180,223			2
3	Housekeeping	138,475	19,697		158,172		158,172		158,172			3
4	Laundry	57,357	12,509	389	70,255		70,255		70,255			4
5	Heat and Other Utilities			89,969	89,969		89,969		89,969			5
6	Maintenance	61,497	6,143	44,142	111,782		111,782		111,782			6
7	Other (specify):* MEDICAL WASTE			345	345		345		345			7
8	**TOTAL General Services**	472,636	238,556	142,108	853,300	(2,934)	850,366		850,366			8
	B. Health Care and Programs											
9	Medical Director			9,308	9,308		9,308		9,308			9
10	Nursing and Medical Records	1,514,718	119,789	5,722	1,640,229	(21,475)	1,618,754	2,455	1,621,209			10
10a	Therapy	43,157	1,874	16,073	61,104	14,500	75,604		75,604			10a
11	Activities	129,928	4,401	2,468	136,797		136,797		136,797			11
12	Social Services	30,875	457	1,374	32,706		32,706		32,706			12
13	Nurse Aide Training	14,462	2,476	500	17,438	10,482	27,920		27,920			13
14	Program Transportation					1,217	1,217		1,217			14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	1,733,140	128,997	35,445	1,897,582	4,724	1,902,306	2,455	1,904,761			16
	C. General Administration											
17	Administrative	74,000			74,000		74,000		74,000			17
18	Directors Fees											18
19	Professional Services			63,087	63,087	(14,500)	48,587		48,587			19
20	Dues, Fees, Subscriptions & Promotions			37,667	37,667	768	38,435	(22,455)	15,980			20
21	Clerical & General Office Expenses	108,737	19,407	52,212	180,356	(26,759)	153,597		153,597			21
22	Employee Benefits & Payroll Taxes			433,341	433,341	38,701	472,042		472,042			22
23	Inservice Training & Education			1,421	1,421		1,421		1,421			23
24	Travel and Seminar			17,530	17,530		17,530	(8,495)	9,035			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			27,512	27,512		27,512		27,512			26
27	Other (specify):*											27
28	**TOTAL General Administration**	182,737	19,407	632,770	834,914	(1,790)	833,124	(30,950)	802,174			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	2,388,513	386,960	810,323	3,585,796		3,585,796	(28,495)	3,557,301			29

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.

SEE ACCOUNTANTS' COMPILATION REPORT

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number PRAIRIEVIEW LUTHERAN HOME #0018044 Report Period Beginning: 1/1/00 Ending: 12/31/00

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			217,425	217,425		217,425		217,425			30
31	Amortization of Pre-Op. & Org.							396	396			31
32	Interest			62,700	62,700		62,700	(13,065)	49,635			32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles											35
36	Other (specify):*											36
37	**TOTAL Ownership**			280,125	280,125		280,125	(12,669)	267,456			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers											39
40	Barber and Beauty Shops			24,729	24,729		24,729		24,729			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			50,508	50,508		50,508		50,508			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**			75,237	75,237		75,237		75,237			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	2,388,513	386,960	1,165,685	3,941,158		3,941,158	(41,164)	3,899,994			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number PRAIRIEVIEW LUTHERAN HOME # 0018044 Report Period Beginning: 1/1/00 Ending: 12/31/00

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Reference	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms	2,455	10		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income	(13,065)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional	(22,455)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(8,495)	24		29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (41,560)		$	30

OHF USE ONLY								
48		49		50		51		52

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense	396	31	33
34	Adjustments for Related Organization Costs (Schedule VII)			34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ 396		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (41,164)		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.			$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops		X			41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44	Exceptional Care Program					44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

SEE ACCOUNTANTS' COMPILATION REPORT

STATE OF ILLINOIS

PRAIRIEVIEW LUTHERAN HOME

ID# 0018044

Report Period Beginning: 1/1/00

Ending: 12/31/00

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	NONDEDUCTIBLE TRAVEL & SEMINARS	$ (8,495)	24	1
2				2
3				3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
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70				70
71				71
72				72
73				73
74				74
75				75
76				76
77				77
78				78
79				79
80				80
81				81
82				82
83				83
84				84
85				85
86				86
87				87
88				88
89				89
90	Total	(8,495)		90

STATE OF ILLINOIS — Summary A

Facility Name & ID Number PRAIRIEVIEW LUTHERAN HOME # 0018044 Report Period Beginning: 1/1/00 Ending: 12/31/00

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	0	0	0	0	0	0	0	0	0	0	0	0	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	0	0	0	0	0	0	0	0	0	0	0	0	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	0	0	0	0	0	0	0	0	0	0	0	0	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	2,455	0	0	0	0	0	0	0	0	0	0	2,455	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	2,455	0	0	0	0	0	0	0	0	0	0	2,455	16
	C. General Administration													
17	Administrative	0	0	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	0	0	0	0	0	0	0	0	0	0	0	19
20	Fees, Subscriptions & Promotions	(22,455)	0	0	0	0	0	0	0	0	0	0	(22,455)	20
21	Clerical & General Office Expenses	0	0	0	0	0	0	0	0	0	0	0	0	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	(8,495)	0	0	0	0	0	0	0	0	0	0	(8,495)	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	**TOTAL General Administration**	(30,950)	0	0	0	0	0	0	0	0	0	0	(30,950)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(28,495)	0	0	0	0	0	0	0	0	0	0	(28,495)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number PRAIRIEVIEW LUTHERAN HOME # 0018044 **Report Period Beginning:** 1/1/00 **Ending:** 12/31/00

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS (to Sch V, col.7)	
30	Depreciation	0	0	0	0	0	0	0	0	0	0	0	0	30
31	Amortization of Pre-Op. & Org.	396	0	0	0	0	0	0	0	0	0	0	396	31
32	Interest	(13,065)	0	0	0	0	0	0	0	0	0	0	(13,065)	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	(12,669)	0	0	0	0	0	0	0	0	0	0	(12,669)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	**TOTAL Special Cost Centers**	0	0	0	0	0	0	0	0	0	0	0	0	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(41,164)	0	0	0	0	0	0	0	0	0	0	(41,164)	45

Facility Name & ID Number PRAIRIEVIEW LUTHERAN HOME # 0018044 Report Period Beginning: 1/1/00 Ending: 12/31/00

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
N/A						

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V		N/A	$			$	$	1
2	V								2
3	V								3
4	V								4
5	V								5
6	V								6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$			$	$ *	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number PRAIRIEVIEW LUTHERAN HOME # 0018044 Report Period Beginning: 1/1/00 Ending: 12/31/00

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	N/A								$		1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number PRAIRIEVIEW LUTHERAN HOME # 0018044 Report Period Beginning: 1/1/00 Ending: 12/31/00

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2	N/A									2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number PRAIRIEVIEW LUTHERAN HOME # 0018044 Report Period Beginning: 1/1/00 Ending: 12/31/00

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1	CAPITAL IMPROVEMENT		X	ADDITIONAL 32 BEDS	VARIES	03/21/96	$ 1,500,000	$ 995,000	9/1/2010	0.0600	$ 49,635	1
2	REVENUE BONDS SERIES											2
3	1995 OF VILLAGE OF											3
4	DANFORTH											4
5												5
	Working Capital											
6												6
7												7
8												8
9	TOTAL Facility Related						$ 1,500,000	$ 995,000			$ 49,635	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$ 1,500,000	$ 995,000			$ 49,635	15

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number PRAIRIEVIEW LUTHERAN HOME # 0018044 Report Period Beginning: 1/1/00 Ending: 12/31/00

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 1999 report.	$	N/A	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	$		2
3. Under or (over) accrual (line 2 minus line 1).	$	#VALUE!	3
4. Real Estate Tax accrual used for 2000 report. (Detail and explain your calculation of this accrual on the lines below.)	$		4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**	$		5
6. Subtract a refund of real estate taxes used previously to calculate a payment rate. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For 19 Tax Year. (Attach a copy of the real estate tax appeal board's decision.)**	$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.	$	#VALUE!	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:		
	1995	8
	1996	9
	1997	10
	1998	11
	1999	12

	FOR OHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 1999	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

Facility Name & ID Number PRAIRIEVIEW LUTHERAN HOME # 0018044 Report Period Beginning: 1/1/00 Ending: 12/31/00

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 49,200 B. General Construction Type: Exterior BRICK Frame STEEL & BRICK Number of Stories

C. Does the Operating Entity? [X] (a) Own the Facility [ ] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.

D. Does the Operating Entity? [X] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [ ] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable)

Luther Place, Independent Living Facility, 18500 sq. ft., 21 units

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [X] YES [ ] NO
If so, please complete the following:

1. Total Amount Incurred: 11,892
2. Number of Years Over Which it is Being Amortized: 30
3. Current Period Amortization: 396
4. Dates Incurred: 1973

Nature of Costs: Interest and closing fees on real estate mortgage
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Bldg/grounds	304,920	1971	$ 9,115	1
2					2
3	TOTALS	304,920		$ 9,115	3

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number PRAIRIEVIEW LUTHERAN HOME # 0018044 Report Period Beginning: 1/1/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	60			1973	$ 549,963	$ 13,749	40	$ 13,749	$	$ 370,503	4
5				1995	1,011,406	26,109	40	26,109		139,433	5
6	32			1996	1,834,874	45,872	40	45,872		168,197	6
7											7
8											8
	Improvement Type**										
9	PLUMBING & HEATING & ELECTRICAL SYSTEM			1973	330,045		20			330,045	9
10	DRINKING FOUNTAIN & EQUIPMENT			1978	2,180		15			2,180	10
11	BUILDING EQUIPMENT			1979	6,984		15			6,984	11
12	AIR CONDITIONER & COMPRESSOR			1980	9,184		20			9,184	12
13	ASPHALT DRIVE			1981	5,775		15			5,775	13
14	GARAGE & FIRE ALARM EQUIPMENT & GRAVEL			1985	12,942	532	20	532		12,942	14
15	WINDOWS & DOOR			1986	1,445	89	15	89		1,332	15
16	WALLPAPER, LIGHTS, WATER HEATER			1987	5,839	369	VARIOUS	369		5,172	16
17	LANDSCAPING, LIGHTS, BOOSTER HEATER			1988	7,120	437	VARIOUS	437		6,005	17
18	AIR CONDITIONING RENOVATION, NURSES STATION			1989	237,555	10,748	VARIOUS	10,748		119,587	18
19	REMODELING IMPROVEMENTS			1991	3,303	132	25	132		1,292	19
20	PARKING LOT, SIDEWALK, PAVEMENT			1993	19,868	1,623	VARIOUS	1,623		11,941	20
21	TREATMENT PLANT			1994	225,522	11,276	20	11,276		69,536	21
22	WATER LINES			1995	16,234	1,082	15	1,082		6,132	22
23	TRENCH W/ELECTRICAL LINES			1995	751	75	10	75		400	23
24	SEWER DRAIN LINE			1995	517	52	10	52		268	24
25	STORM DRAIN			1995	8,181	545	15	545		2,726	25
26	WATER LINE UPGRADE			1995	10,630	266	40	266		1,329	26
27	PARKING LOT			1995	9,211	461	20	461		2,303	27
28	SIDEWALK			1995	19,696	985	20	985		4,924	28
29	GARAGE			1995	25,220	630	40	630		3,152	29
30	CONCRETE ENCLOSURE FOR DUMPSTER			1995	5,775	429	15	429		2,146	30
31	BUILDING IMPROVEMENTS IN HALLWAYS			1995	8,858	869	10	869		4,696	31
32	WALK IN COOLER			1995	12,936	862	15	862		4,987	32
33	WALK IN FREEZER			1995	12,935	862	15	862		4,987	33
34	BUILT IN CABINETS			1995	5,346	535	10	535		2,760	34
35											35
36	TOTAL (lines 4 thru 35)				$ 4,400,295	$ 118,589		$ 118,589	$	$ 1,300,918	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number PRAIRIEVIEW LUTHERAN HOME # 0018044 Report Period Beginning: 1/1/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	BALANCE FORWARD				4,400,295	118,589		118,589		1,300,918	9
10	WINDOW TREATMENTS			1995	9,576	1,529	5	1,529		9,576	10
11	DOUBLE COMPARTMENT SINK			1995	2,015	202	10	202		1,117	11
12	LANDSCAPING			1995	772	77	10	77		373	12
13	DRAINAGE TILE			1996	1,839	92	20	92		391	13
14	DRIVEWAY			1996	2,790	140	20	140		582	14
15	WINDOW TREATMENTS			1996	877	88	10	88		439	15
16	DOOR			1996	550	55	10	55		273	16
17	CARPET			1996	12,267	1,227	10	1,227		5,378	17
18	TILE FLOORING			1996	631	63	10	63		295	18
19	WATER METER			1996	1,397	70	20	70		291	19
20	DOOR			1996	758	76	10	76		379	20
21	WIND BREAK FOR DOOR			1996	705	71	10	71		347	21
22	WIRING FOR SEWER PLANT			1996	1,219	122	10	122		528	22
23	CHAPEL PARTITION			1996	6,350	159	40	159		794	23
24	FINAL PAYMENT TO ARCHITECT			1996	14,500	362	40	362		1,616	24
25	LANDSCAPING			1997	5,268	493	15	493		1,552	25
26	PARKING LOT LIGHTS			1997	1,869	125	15	125		385	26
27	CARPET AND BASE-HALLWAYS			1997	4,481	448	10	448		1,657	27
28	WALLPAPER/HALLWAYS			1997	11,838	1,184	10	1,184		3,697	28
29	LAUNDRY AREA RENOVATION			1997	2,327	233	10	233		828	29
30	WINDOW TREATMENTS			1997	550	55	10	55		174	30
31	SECURITY SYSTEM			1997	9,529	635	15	635		2,435	31
32	CARPET/TILE FLOORING FOR ALZH UNIT			1997	47,225	4,723	10	4,723		17,668	32
33	DRIVEWAY/PARKING LOT			1997	13,637	909	15	909		3,333	33
34	COURTYARD IMPROVEMENTS			1997	58,578	5,150	VARIOUS	5,150		18,304	34
35	WINDOW TREATMENTS			1997	684	68	10	68		251	35
36	TOTAL (lines 4 thru 35)				$ 4,612,527	$ 136,945		$ 136,945	$	$ 1,373,581	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number PRAIRIEVIEW LUTHERAN HOME # 0018044 Report Period Beginning: 1/1/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	BALANCE FORWARD				4,612,527	136,945		136,945		1,373,581	9
10	CORRIDOR FIXTURES & WIRING			1998	1,008	25	40	25		75	10
11	ARCHITECT FEE-FINAL PAYMENT			1998	718	18	40	18		54	11
12	SHOWER GRAB BARS			1998	592	15	40	15		45	12
13	DOOR ALARM			1998	4,066	102	40	102		267	13
14	LANDSCAPING			1998	750	75	10	75		271	14
15	PARKING LOT			1998	64,900	4,327	15	4,327		10,463	15
16	PUMP TREATMENT PLANT			1998	1,000	100	10	100		250	16
17	LAUNDRY ROOM RENOVATION			1999	30,066	752	40	752		1,190	17
18	KITCHENETTE BUILT IN CABINETS-NURSING STATION			1999	570	57	10	57		100	18
19	CARPET-RESIDENTS ROOM			1999	9,979	1,426	7	1,426		2,139	19
20	WALLPAPER-RESIDENT ROOMS			1999	21,698	3,100	7	3,100		5,425	20
21	AIR CONDITIONER			1999	507	51	10	51		85	21
22	WINDOW TREATMENTS-RESIDENT ROOMS			1999	22,526	3,218	7	3,218		4,023	22
23	AIR CONDITIONER UPGRADE-BACK HALL			1999	20,403	1,126	20	1,126		1,314	23
24	UNDERGROUND CONDUIT			1999	1,893	95	20	95		119	24
25	GAZEBO			1999	7,411	741	10	741		803	25
26	NEW CARPETING			2000	23,355	195	10	195		195	26
27	REDO BLACKTOP			2000	3,251	72	15	72		72	27
28	FIRE ALARM SYSTEM			2000	4,450	334	10	334		334	28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36	TOTAL (lines 4 thru 35)				$ 4,831,670	$ 152,774		$ 152,774	$	$ 1,400,805	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number PRAIRIEVIEW LUTHERAN HOME # 0018044 Report Period Beginning: 1/1/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
37	Purchased in Prior Years	$ 480,226	$ 53,493	$ 53,493	$		$ 248,785	37
38	Current Year Purchases	120,790	7,258	7,258			7,258	38
39	Fully Depreciated Assets	177,901					177,901	39
40								40
41	TOTALS	$ 778,917	$ 60,751	$ 60,751	$		$ 433,944	41

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
42	RES TRANSPORTATION	1993 FORD VAN	1993	$ 39,000	$ 3,900	$ 3,900	$	10	$ 30,225	42
43										43
44										44
45										45
46	TOTALS			$ 39,000	$ 3,900	$ 3,900	$		$ 30,225	46

E. Summary of Care-Related Assets

		1 Reference	2 Amount		
47	Total Historical Cost	(line 3,col.4 + line 36,col.4 + line 41,col.1 + line 46,col.4)	$ 5,658,702	47	
48	Current Book Depreciation	(line 36,col.5 + line 41,col.2 + line 46,col.5)	$ 217,425	48	
49	Straight Line Depreciation	(line 36,col.7 + line 41,col.3 + line 46,col.6)	$ 217,425	49	**
50	Adjustments	(line 36,col.8 + line 41,col.4 + line 46,col.7)	$	50	
51	Accumulated Depreciation	(line 36,col.9 + line 41,col.6 + line 46,col.9)	$ 1,864,974	51	

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
52	LAND DONATED 128259	$ 35,540	$	$	52
53	SQUARE FEET IN 1993 TO BE				53
54	USED FOR FUTURE EXPANSION				54
55					55
56					56
57	TOTALS	$ 35,540	$	$	57

G. Construction-in-Progress

	Description	Cost	
58		$	58
59			59
60			60
61		$	61

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

Facility Name & ID Number PRAIRIEVIEW LUTHERAN HOME # 0018044 Report Period Beginning: 1/1/00 Ending: 12/31/00

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: _____

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. ☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:	N/A			$			3
4	Additions							4
5								5
6								6
7	TOTAL				$ **			7

8. List separately any amortization of lease expense included on page 4, line 34.
This amount was calculated by dividing the total amount to be amortized
by the length of the lease _____.

9. Option to Buy: ☐ YES ☐ NO Terms: _____ *

10. Effective dates of current rental agreement:
Beginning _____
Ending _____

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2001	$
13.	/2002	$
14.	/2003	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? ☐ YES ☐ NO

16. Rental Amount for movable equipment: $ _____ Description: _____
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			$	$	17
18					18
19					19
20					20
21	TOTAL		$	$	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number PRAIRIEVIEW LUTHERAN HOME # 0018044 Report Period Beginning: 1/1/00 Ending: 12/31/00

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD? [X] YES [ ] NO

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
- IN-HOUSE PROGRAM [X]
- IN OTHER FACILITY [ ]
- COMMUNITY COLLEGE [ ]
- HOURS PER AIDE 85

3. CLINICAL PORTION:
- IN-HOUSE PROGRAM [X]
- IN OTHER FACILITY [ ]
- HOURS PER AIDE 42

B. EXPENSES

ALLOCATION OF COSTS (d)

		1 Facility Drop-outs	2 Facility Completed	3 Contract	4 Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies	558	1,116		1,674
3	Classroom Wages (a)	1,517	6,322		7,839
4	Clinical Wages (b)	265	2,979		3,244
5	In-House Trainer Wages (c)	2,893	11,570		14,463
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests		700		700
9	TOTALS	$ 5,233	$ 22,687	$	$ 27,920
10	SUM OF line 9, col. 1 and 2 (e)	$ 27,920			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	14
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	7
2. From other facilities (f)	
TOTAL TRAINED	21

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number PRAIRIEVIEW LUTHERAN HOME # 0018044 Report Period Beginning: 1/1/00 Ending: 12/31/00

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	10A	1391.25 hrs	$ 22,573	125	$ 5,055	$ 75	1,517	$ 27,703	1
2	Licensed Speech and Language Development Therapist	10A	hrs		39	1,992		39	1,992	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10A	1555 hrs	21,938	244	9,094	243	1,799	31,275	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescrpts							9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify):									13
14	TOTAL			$ 44,511	409	$ 16,141	$ 318	3,355	$ 60,970	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number PRAIRIEVIEW LUTHERAN HOME # 0018044 Report Period Beginning: 1/1/00 Ending: 12/31/00

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/00 (last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 221,392	$	1
2	Cash-Patient Deposits	109,762		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	479,551		3
4	Supply Inventory (priced at FIFO)	18,701		4
5	Short-Term Investments			5
6	Prepaid Insurance	26,980		6
7	Other Prepaid Expenses	7,830		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): DUE FROM OTHER FUNDS	77,929		9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 942,145	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	44,655		13
14	Buildings, at Historical Cost	4,475,806		14
15	Leasehold Improvements, at Historical Cost	250,660		15
16	Equipment, at Historical Cost	923,121		16
17	Accumulated Depreciation (book methods)	(1,864,974)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 3,829,268	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 4,771,413	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 339,011	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	94,845		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	65,575		30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable	19,900		33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36				36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 519,331	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable	995,000		41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 995,000	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 1,514,331	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 3,257,082	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 4,771,413	$	48

SEE ACCOUNTANTS' COMPILATION REPORT

***(See instructions.)**

Facility Name & ID Number PRAIRIEVIEW LUTHERAN HOME # 0018044 Report Period Beginning: 1/1/00 Ending: 12/31/00

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total		
1	**Balance at Beginning of Year, as Previously Reported**	$ 3,255,793	1	
2	Restatements (describe):		2	
3			3	
4			4	
5			5	
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 3,255,793	6	
	A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	(276,246)	7	
8	Aquisitions of Pooled Companies		8	
9	Proceeds from Sale of Stock		9	
10	Stock Options Exercised		10	
11	Contributions and Grants		11	
12	Expenditures for Specific Purposes		12	
13	Dividends Paid or Other Distributions to Owners	( )	13	
14	Donated Property, Plant, and Equipment		14	
15	Other (describe) ROUNDING	3	15	
16	Other (describe)		16	
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ (276,243)	17	
	B. Transfers (Itemize):			
18	TRANSFER FROM FOUNDATION	277,532	18	
19			19	
20			20	
21			21	
22			22	
23	**TOTAL Transfers (sum of lines 18-22)**	$ 277,532	23	
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 3,257,082	24	*

*** This must agree with page 17, line 47.**

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number PRAIRIEVIEW LUTHERAN HOME # 0018044 Report Period Beginning: 1/1/00 Ending: 12/31/00

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 3,707,729	1
2	Discounts and Allowances for all Levels	(205,426)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 3,502,303	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	58,126	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 58,126	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements	1,250	11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care	23,354	13
14	Non-Patient Meals	8,486	14
15	Telephone, Television and Radio	4	15
16	Rental of Facility Space		16
17	Sale of Drugs	9,808	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	1,274	19
20	Radiology and X-Ray	358	20
21	Other Medical Services		21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 44,534	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	13,065	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 13,065	26
	E. Other Revenue (specify):**		
27	**Settlement Income (Insurance, Legal, Etc.)**		27
28	**ASSESSSMENT FEE REIMBURSEMENT**	1,200	28
28a	**ADMINISTRATIVE FEE FROM OTHER FUNDS**	45,684	28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 46,884	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 3,664,912	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	853,300	31
32	Health Care	1,897,582	32
33	General Administration	834,914	33
	B. Capital Expense		
34	Ownership	280,125	34
	C. Ancillary Expense		
35	Special Cost Centers	24,729	35
36	Provider Participation Fee	50,508	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 3,941,158	40
41	**Income before Income Taxes (line 30 minus line 40)****	(276,246)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (276,246)	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? NO If not, please attach a reconciliation.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation. SEE ACCOUNTANTS' COMPILATION REPORT**

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Facility Name & ID Number PRAIRIEVIEW LUTHERAN HOME # 0018044 Report Period Beginning: 1/1/00 Ending: 12/31/00

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	3,880	4,160	$ 82,913	$ 19.93	1
2	Assistant Director of Nursing	3,488	3,729	75,321	20.20	2
3	Registered Nurses	16,058	17,623	358,635	20.35	3
4	Licensed Practical Nurses	13,260	14,926	214,352	14.36	4
5	Nurse Aides & Orderlies	82,395	85,822	770,149	8.97	5
6	Nurse Aide Trainees	2,141	2,141	11,084	5.18	6
7	Licensed Therapist	2,928	2,946	44,511	15.11	7
8	Rehab/Therapy Aides	1,129	1,184	11,336	9.57	8
9	Activity Director	1,920	2,080	20,517	9.86	9
10	Activity Assistants	14,586	15,324	109,411	7.14	10
11	Social Service Workers	2,418	2,738	30,875	11.28	11
12	Dietician					12
13	Food Service Supervisor	2,040	2,080	27,484	13.21	13
14	Head Cook	5,066	5,306	45,894	8.65	14
15	Cook Helpers/Assistants	18,277	19,271	141,928	7.36	15
16	Dishwashers					16
17	Maintenance Workers	3,679	3,928	61,497	15.66	17
18	Housekeepers	14,640	15,401	138,475	8.99	18
19	Laundry	7,390	7,767	57,357	7.38	19
20	Administrator	1,920	2,080	74,000	35.58	20
21	Assistant Administrator					21
22	Other Administrative	3,680	3,952	61,092	15.46	22
23	Office Manager					23
24	Clerical	3,654	3,721	36,532	9.82	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	295	340	4,037	11.87	31
32	Other Health Care(specify)					32
33	Other(specify) CHAPLAIN	523	555	11,113	20.02	33
34	TOTAL (lines 1 - 33)	205,367	217,074	$ 2,388,513 *	$ 11.00	34

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	144	$ 6,357	1-3	35
36	Medical Director	192	4,800	9-3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	12	300	10-3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	19	1,092	11-3	44
45	Social Service Consultant	24	1,374	12-3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	391	$ 13,923		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses		$		50
51	Licensed Practical Nurses				51
52	Nurse Aides				52
53	TOTAL (lines 50 - 52)		$		53

SEE ACCOUNTANTS' COMPILATION REPORT

* This total must agree with page 4, column 1, line 45.

** See instructions.

Facility Name & ID Number PRAIRIEVIEW LUTHERAN HOME # 0018044 Report Period Beginning: 1/1/00 Ending: 12/31/00

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
CAROL PETERS	ADMINISTRATOR		$ 74,000
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 74,000

B. Administrative - Other

Description	Amount
	$
TOTAL (agree to Schedule V, line 17, col. 3)	$
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
SPESIA, AYERS & ARDAUGH	ATTORNEY	$ 15,912
KATTEN, MUCHIN & ZAVIS	ATTORNEY	5,723
FOX CPA GROUP, LTD	ACCOUNTANT	5,250
ADP	PAYROLL SERVICE	7,510
LZT	CONSULTANTS	5,791
AMERICAN ARBITRATION	CONSULTANTS	2,000
SMALL PARKER & BLOSSOM	FORM 5500 REPORTING	350
AMERICAN EXPRESS TAX	MEDICARE CONSULTING	2,427
JOHN SPESIA	ARCHITECTURAL WORK	176
ALTSCHULER, MELVOIN	MEDICARE COST REPORT	3,193
GARDNER & WHITE	FORM 5500 REPORTING	255
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $2500 attach copy of invoices.)		$ 48,587

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 57,102
Unemployment Compensation Insurance	17,476
FICA Taxes	176,515
Employee Health Insurance	170,677
Employee Meals	11,942
Illinois Municipal Retirement Fund (IMRF)*	
EMPLOYEE INCENTIVES	9,283
PENSION	29,047
TOTAL (agree to Schedule V, line 22, col.8)	$ 472,042

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	6,729
Health Care Worker Background Check	
(Indicate # of checks performed 64)	768
VIEWS(NEWSLETTER)	9,337
YELLOW PAGE ADVERTISING	2,471
SUBSCRIPTIONS	3,372
OTHER PUBLIC RELATIONS	10,514
DUES	5,244
NONALLOWABLE SUBS & DUES	(901)
Less: Public Relations Expense	(19,083)
Non-allowable advertising	( )
Yellow page advertising	(2,471)
TOTAL (agree to Sch. V, line 20, col. 8)	$ 15,980

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$ 3,844
In-State Travel	3,110
Seminar Expense	10,576
NONALLOWABLE	(8,495)
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 9,035

* Attach copy of IMRF notifications

**See instructions.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number PRAIRIEVIEW LUTHERAN HOME # 0018044 Report Period Beginning: 1/1/00 Ending: 12/31/00

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY1997	FY1998	FY1999	FY2000	FY2001	FY2002	FY2003	FY2004	FY2005
1	N/A		$		$	$	$	$	$	$	$	$	$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number PRAIRIEVIEW LUTHERAN HOME # 0018044 Report Period Beginning: 1/1/00 Ending: 12/31/00

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **NO**

(2) Are there any dues to nursing home associations included on the cost report? **YES**
If YES, give association name and amount. **LSN-3819.20/LUTH SERVICES IN AMERICA-415**

(3) Did the nursing home make political contributions or payments to a politica action organization? **NO** If YES, have these costs been properly adjusted out of the cost report?

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **NO** If YES, what is the capacity?

(5) Have you properly capitalized all major repairs and equipment purchases? **YES**
What was the average life used for new equipment added during this period? **10 YEARS**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **38,324** Line **10**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **YES** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **NO**
If YES, give effective date of lease.

(9) Are you presently operating under a sublease agreement? YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO **X** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. $ **50,508**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **NO** If YES, attach an explanation of the allocation.

SEE ACCOUNTANTS' COMPILATION REPORT

(13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **YES**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **NO** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **11,942** Has any meal income been offset against related costs? **NO** Indicate the amount. $

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **YES**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **NO** If YES, please indicate the amount of income earned from such a program during this reporting period. $
c. What percent of all travel expense relates to transportation of nurses and patients? **N/A**
d. Have vehicle usage logs been maintained? **YES**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **YES**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **N/A**
g. Does the facility transport residents to and from day training? NO
Indicate the amount of income earned from providing such transportation during this reporting period. $

(17) Has an audit been performed by an independent certified public accounting firm? **YES**
Firm Name: **FOX CPA GROUP, LTD** The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? **YES** If no, please explain.

(18) Have all costs which do not relate to the provision of long term care been adjusted ou out of Schedule V? **YES**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services performed been attached to this cost report? **YES**
Attach invoices and a summary of services for all architect and appraisal fees.